This is a Voluntary Program.

EMPLOYEE NUMBER_____ DATE OF BIRTH_____

LAST NAME_____ FIRST NAME_____

ADDRESS_____email ADDRESS_____

CITY_____ STATE_____ZIPCODE_____

HOME OR CELL PHONE #_____ WORK PHONE_____

COMPANY_____ BUILDING_____

JOB TITLE_____ SUPERVISOR_____

PERSONAL PHYSICIAN NAME_____

ADDRESS_____

WELLNESS SUGGESTIONS:_____

_____

_____

Informed Consent

I hereby release and discharge NCI-Frederick Wellness Program staff and all other participating agencies from all injuries or damages suffered by me as a result of my voluntary participation in Wellness Program activities. I agree that the Wellness Program staff and all participating agencies are under no obligation to provide physical examination or other evidence of my fitness or ability to participate in such activities, these being my sole responsibility. I also understand that my participation in these programs does not substitute for medical care or psychosocial counseling/support.

Signature_____ _____**Date**_____